Medicaid Information Bulletin

April 1999

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99 - 25 Health Common Procedure Coding System - 1999 Revisions

Effective for dates of services on or after **January 1, 1999**, Medicaid accepts the 1999 version of the Health Common Procedure Coding System (HCPCS). Codes include the 1999 Physicians' Current Procedural Terminology (CPT) codes as well as all other HCPCS codes. For services on and after April 1, 1999, providers must use the 1999 HCPCS codes. Any 1998 HCPCS codes discontinued in 1999 may be used ONLY for dates of services prior to April 1, 1999.

Other articles in this Bulletin describe coding changes used by specific provider types such as physicians, medical suppliers and so forth. If you have a question concerning billing the 1999 HCPCS codes, please contact Medicaid Information. □

99 - 26 HMO Choice

Medicaid has client advocates called Health Program Representatives (HPRs) who try to help with any type of problem with a managed care plan or HMO. Medicaid clients who are experiencing any problems with their HMO have the right to change to a different HMO.

A client who wants to change the HMO selection should contact his or her Health Program Representative (HPR). The HPR is located in the office where the client was determined eligible for Medicaid. A client can call Medicaid Information and get the telephone number for the HPR. □

99 - 27 Claims Must Have Correct Provider Number

Claims must have a correct provider number to be accepted. Medicaid must return paper claims which do not have a correct provider number on the claim form. On the HCFA-1500, enter the provider number in Box 33. On the ADA form, enter the number in box 18.

Please double check the provider number to ensure speedy processing of your claim. An incorrect or missing number on a paper claim causes delays in payment. A provider must wait until the claim is returned in order to correct the error. (A provider attempting to submit an electronic claim with an incorrect or missing number is immediately advised to make this correction, so the delay is minimal.)

99 - 28 Medicaid Budget Hearing for Fiscal Year 2001

The Department of Health invites you to attend a special Medical Care Advisory Committee (MCAC) meeting to obtain public input on the Medicaid and UMAP (Utah Medial Assistance Program) budgets for Fiscal Year 2001. The meeting will be held

Thursday, July 15, 1999
4:00 p.m. until 6:00 p.m
at
the State Office Building Auditorium
(north of the State Capitol Building)

Fiscal Year 2001 is July 1, 2000 through June 30, 2001. The MCAC is an advisory group which recommends funding and program directions to the Department of Health and the Governor.

If you know of special medical needs not being met by the Medicaid or UMAP programs, or want to speak on a budgetary matter of importance to you, please come prepared to make a short (no more than five minutes) presentation to the Committee. Copy services will be provided if you have a handout. SIGNED PETITIONS ARE ENCOURAGED. Your input will assist the MCAC in recommending a budget that will be more representative of Medicaid and UMAP providers and clients.

If you cannot attend the public hearing, but would like to write to the Committee of special medical needs, please mail comments by Tuesday, July 6, 1999, to:

MCAC
Box 143105
Salt Lake City, UT 84114-3105

99 - 29 Dental Care Services: Restorations

Medicaid now covers two additional codes for posterior one surface composite restorations, limited to occlusal and buccal surfaces. The codes are:

D2380, Composite Resin-one surface posterior, primary teeth — $21.60

D2385, Composite Resin-one surface posterior, permanent teeth — $27.00

The Utah Medicaid Provider Manual for Dental Care Services is being revised. When the revision is issued, these codes will be included. □

99 - 30 Make Sure Medicaid Clients Receive All Medically Necessary Services

A Medicaid provider who accepts a Medicaid client for treatment accepts the responsibility to make sure the client receives all medically necessary services. A provider's responsibilities include making referrals to other Medicaid providers; ensuring ancillary services are also delivered by a Medicaid provider; and ensuring the client receives all medically necessary services at no cost.

▸ Appropriate Referrals

When the Medicaid patient has a Primary Care Provider, the provider must provide an appropriate referral before Medicaid will pay for medical services received from any other provider. The other provider must be a Medicaid provider as well. Reference: Utah Medicaid Provider Manual, Section 1, *General Information*, Chapter 6 - 10, *Physician Referrals*.

▸ Ancillary Services by Participating Provider

Make sure ancillary services, such as lab, x-ray, and anesthesiology, are delivered by a participating Medicaid provider. Please give **all** ancillary providers a copy of the patient's Medicaid Identification Card or, at minimum, the patient's Medicaid Identification number. In addition, when the service requires Prior Authorization (PA) and a PA number is obtained from Medicaid, please give that number to other providers rendering service to the patient. Reference: Utah Medicaid Provider Manual, Section 1, *General Information*, Chapter 5 - 6, *Ancillary Services*.

▸ Hospital Responsibilities

A hospital which accepts a Medicaid patient for treatment accepts the responsibility to make sure that the patient receives **all** medically necessary services from **Medicaid** providers. This includes physicians, surgeons, anesthesiologists, laboratory, X-ray, pharmacy, rehab and other providers on staff. The hospital administration is accountable for the quality of care provided to patients.

Quality care includes the provision of care by practitioners who meet all requirements of the Utah Medicaid program, who agree to abide by Medicaid rules to provide medically necessary services, and who accept the Medicaid reimbursement as payment in full.

If providers (including but not limited to anesthesiologists) do not accept a particular patient for treatment, or will not accept the Medicaid payment as payment in full, the hospital is still responsible for assuring delivery of medically necessary services.

Should the Medicaid client receive medically necessary services from a non-Medicaid provider, the hospital is financially responsible for covering the services. Neither the provider nor the hospital may bill the patient for such services. For example, if the hospital's anesthesiologist does not accept Medicaid as payment in full, the hospital must provide an anesthesiologist who will accept the payment without requiring a copayment or any other charge. Under federal Medicaid law, pregnant women in particular may not be subjected to cost sharing for Medicaid services.

Hospital Manual Updated

The preceding paragraphs marked with a vertical line in the margin have been added to Section 2 of the Utah Provider Manual for Hospital Services, Chapter 1, GENERAL POLICY, page 2, as new paragraphs two, three and four.

Because there are other pages corrected in Section 2, instructions for replacing the page are in Bulletin 99 - 39, *Hospital Manual Updated*.

Physician Manual Updated

The second sentence in Section 2 of the Utah Provider Manual for Physician Services, Chapter 1, GENERAL POLICY, page 2, is modified as follows:

"The program is based on the art and science of caring for those who are ill through the practice of medicine or osteopathy by a practitioner who (1) meets all requirements necessary to participate in the Utah Medicaid program, (2) who agrees to abide by Department rules to render medically necessary physician services in accordance with a specific, signed provider agreement, and (3) who accepts Utah Medicaid payment as payment in full."

Because there are other pages corrected in Section 2, instructions for replacing the page are in Bulletin 99 - 33, *Physician Services Manual Updated*. □

Billing Medicaid Patients Prohibited!

Medicaid clients should NEVER be billed for services covered by Medicaid. Medicaid providers are required to follow policy and procedures concerning, but not limited to, covered services, limitations, prior authorization, and claim submission. The Medicaid payment is reimbursement in full! If a Medicaid provider does not follow the policy and procedures, and Medicaid will not reimburse for services to the client, the provider may not seek payment from the Medicaid client instead. Reference: Utah Medicaid Provider Manual, Section 1, *General Information*, Chapter 6 - 8, *Billing Patients*.

Limited Exceptions on Billing Patients

There are four, limited circumstances under which a provider may bill a Medicaid client. Briefly, these are (1) for non-covered services requested in writing by the client; (2) when a Form MEEU is attached to Medicaid Card and the client has agreed to pay a portion of his or her medical bills to become eligible for Medicaid; (3) the client's Medicaid Card states a co-payment is due for non-emergency use of a hospital emergency department or pharmacy service; and (4) broken appointments. For complete information on criteria which apply to these circumstances, refer to the Utah Medicaid Provider Manual, Section 1, *General Information*, Chapter 6 - 9, *Exceptions to Prohibition on Billing Patients*.

99 - 31 Immunization Schedule for 1999

Physicians, osteopaths and licensed nurse practitioners will find attached the 1999 Recommended Childhood Immunization Schedule. This schedule is in two Utah Medicaid Provider Manuals: Physician Services and Child Health Evaluation and Care Program (CHEC) Services. In the Physician Services manual, the Immunization Schedule is one of the attachments. In the CHEC Services manual, the schedule is Appendix B on page 15 of Section 2.

Updating the Physician Services Manual

Because many physicians are also CHEC providers, the 1999 Immunization Schedule is printed as it appears in Section 2 of the CHEC manual; that is, as Appendix B on page 15. In the Physician Services manual, remove the outdated Immunization Schedule and replace with the 1999 schedule attached. Providers who are not also CHEC providers can disregard Appendix A on page 14.

Updating the CHEC Manual

CHEC providers, please remove the old pages 14 - 15 (Appendix A and B) in Section 2 of the CHEC manual and replace it with pages 14 - 15 attached. ☐

99 - 32 Hospital Surgical Procedures (ICD-9-CM Codes)

The new CPT code 45126, pelvic exenteration for colorectal malignancy, requires prior authorization. This code is related to ICD-9-CM codes 68.8, 154.0, and 154.1.

These codes are added to the Hospital Surgical Procedures List which is included with the Medicaid Provider Manuals for physicians and for hospitals. The revised list is effective January 1, 1999, in accordance with instructions for use of the 1999 HCPCS codes. For more information on the effective dates for 1999 HCPCS updates, refer to Bulletin 99 - 25, *Health Common Procedure Coding System - 1999 Revisions.*

Code changes are as follows: CPT code 45126 is added to ICD-9 code 68.8, pelvic evisceration, on page 13 of the Hospital Surgical Procedures List. The other two related ICD-9 codes 154.0, Malignant neoplasm of rectosigmoid junction, and 154.1, Malignant neoplasm of rectum, are also added to this page.

Attached are updated pages 13 - 14 of the 1999 Hospital Surgical Procedures List. On the corrected page, vertical lines are in the margin next to text which changed. If you have a question, contact Medicaid Information. ☐

99 - 33 Physician Services Manual Updates

Six updates to Section 2 of the Utah Medicaid Provider Manual for Physician Services are described below. Corrected pages for Section 2 are attached. Instructions for filing the pages are at the end of this bulletin.

1. Medicaid Reimbursement as Payment in Full

A requirement is that the provider accept the Utah Medicaid reimbursement as payment in full. A Medicaid patient cannot be billed for services provided, except under the conditions stated in Section 1, *General Information*, Chapter 6 - 8, *Billing Patients*. These reminders are added to Chapter 1, *GENERAL POLICY*, (page 2).

2. Medically Necessary Services

Bulletin 99-30, *Make Sure Medicaid Clients Receive All Medically Necessary Services*, updated one page: Chapter 1, *GENERAL POLICY*, page 2.

3. Coverage of Drugs

Information has been added on Medicaid criteria for coverage of drugs (Section 2, Chapter 2, COVERED SERVICES, item 19, page 8). Additional criteria and limitations for item 19 are as follows:

a. Medicaid covers most medications prescribed by qualified practitioners as a Medicaid benefit, in compliance with Federal law (42 CFR 440.120). Coverage requirements are described in the Utah Medicaid Provider Manual for Pharmacy Services. A copy of the Pharmacy Manual may be obtained by contacting Medicaid Information.

b. Medicaid has additional requirements for drugs identified on the Drug Criteria and Limits List attached to this manual, including limits or requirements for prior authorization.

c. Nonprescription, over-the-counter items are limited to those OTC drugs on the Over the Counter Drug List attached to this manual.

Both of these lists are included with the Medicaid Provider Manual for Physician Services.

4. Coverage of Medical Supplies

Information has been added on Medicaid criteria for coverage of medical supplies (Section 2, Chapter 2, COVERED SERVICES, item 27, page 9). Additional information for item 27 is as follows:

a. The Utah Medicaid Program covers medical supplies and equipment under four conditions: (1) The supplies and equipment are medically necessary; (2) they are ordered by a physician; (3) they meet the standards stated in policy and the Medical Supplies List, and they are within the limits specified; and (4) they are on the Medical Supplies List included with this manual. Coverage requirements are described in the Utah Medicaid Provider Manual for Medical Supplies. A copy of this manual may be obtained by contacting Medicaid Information.

Medical necessity does not include use primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort. The physician's order must list each item required, a medical necessity, and be signed and dated by the physician or other licensed medical practitioner. An item simply marked on a preprinted multiple item order sheet is not acceptable.

b. The Child Health Evaluation and Care (CHEC) Program may approve medical supplies and medical equipment which are medically necessary for children less than 21 years of age. For specific information, please refer to the Utah Medicaid Provider Manual for Child Health Evaluation and Care (CHEC) Program Services. A copy of this manual may be obtained by contacting Medicaid Information.

5. Injection Administration Codes

Medicaid limits the use of injection administration codes. The limitation is that an office visit code and a vaccine or toxoid product code can be billed together, or the vaccine or toxoid product code and the administration code can be billed together, but all three codes cannot be billed for the same service on the same day. This limitation is added to Section 2, Chapter 3, LIMITATIONS, page 17.

6. Prior Authorization and Retroactive Authorization

Information from Bulletin 99-23, *Medicaid Authorization: Prior and Retroactive*, issued in January 1999, has been added to Section 2 as new Chapters 4, Prior Authorization, and 4 - 1, Retroactive Authorization.

Replacement Pages for Section 2

Attached to this bulletin are nine replacement pages for the Utah Medicaid Provider Manual for Physician Services. Each page has a revision date at the top right side of the page. This date indicates the month in which the change is effective. A vertical line is placed in the margin next to text which has changed.

Remove the existing pages in Section 2 and replace with the attached pages listed below.

- Table of Contents for PHYSICIAN SERVICES and ANESTHESIOLOGY
- page 1 (Table of Contents), adding Chapters 4 and 4-1, renumbering the remaining chapter.
- pages 2 - 3 (Chapter 1), clarifying the requirement to accept the Medicaid reimbursement as payment in full.
- pages 8 - 9 (Chapter 2), adding information on Medicaid criteria for coverage of drugs and medical supplies.
- pages 16 - 17 (Chapter 3), adding the limitation on injection administration codes.
- pages 17A - 17B (new Chapters 4, Prior Authorization, and 4 - 1, Retroactive Authorization). Add this page between the existing pages 17 and 18.
- pages 18 - 19, renumbering Chapter 4, Non-Covered Services, as Chapter 5.

□

99 - 34 1999 CPT Codes

This bulletin describes 1999 physicians' Current Procedural Terminology (CPT) codes which are not covered by Medicaid, require prior authorization, or have other limitations. The HCPCS descriptors, abbreviated in this bulletin, are given in full in the code list. For more information regarding the 1999 revisions to HCPCS, refer to Bulletin 99 - 25, *Health Common Procedure Coding System - 1999 Revisions*.

Medical and Surgical Procedures Codes Not Covered or Limited

The Medical and Surgical Procedures Code List has been updated to include 1999 CPT codes which are not covered, require prior authorization or have other limitations. Following is a description of those changes. Corrected code list pages are attached. Instructions for filing the pages are at the end of this bulletin.

CPT Codes Not Covered

Medicaid does not cover the following CPT codes included in the 1999 HCPCS update:

83013 Helicobacter Pylori, breath test analysis;
83014 drug administration and sample collection

92970 Cardioassist method of circulatory assist; internal. Related to ICD.9.CM: 37.67
92971 external

89264 Sperm identification from testis tissue, fresh or cryopreserved

90281 through 90396 (immune globulin products)
(Note: Continue to use existing "J" codes for these products in conjunction with administration codes 90780 - 90784)

Other Non-Covered Codes

Medicaid does not cover the following 'G' codes which are Medicare-specific:

G0108 Diabetes outpatient self-management training. .
G0109 Diabetes self-management training services. . .
G0123 Screening cytopathology. . .
G0124 Screening cytopathology . . .
G0125 PET Lung imaging . . .
G0126 PET Lung imaging . . .
G0127 Trimming dystrophic nails
G0128 Direct skilled nursing service. . .
G0130 Single energy absorptiometry bone density study. . .
G0131 Computer tomography bone mineral density study. . .
G0132 Computerized tomography bone mineral density study. . .
G0141 Screening cytopathology smears. . .
G0143 through G0148 Screening cytopathology . . .

Discontinued Codes

HCPCS codes discontinued in 1999 have been removed from Medicaid lists. Medicaid did not cover the following codes on the Medical and Surgical Procedures Code List, so

there are no replacements:

85029, 85030 Additional automated hemogram indices
90730 Immunization, Hepatitis A vaccine

Discontinued codes removed from the list CPT Procedures Codes NOT Authorized For An Assistant Surgeon are 11731, 16040, 63690, 63691, and 97265.

New CPT Code Requiring Prior Authorization

Medicaid covers CPT code 45126 with prior authorization which may be requested by telephone. The abbreviated code descriptor is *pelvic exenteration for colorectal malignancy. . .*

Prior authorization criteria for code 45126 are listed in Criteria #14 at the end of the Medical and Surgical Procedures Code List. There are three related ICD-9 codes (68.8, 154.0, 154.1). For more information on the ICD-9 codes, refer to Bulletin 99 - 32, *Hospital Surgical Procedures (ICD-9-CM Codes)*.

New Unspecified Code Requiring Documentation

Medicaid may cover CPT code 90399, unlisted immune globulin, provided documentation is attached to the claim. Prior approval is not required.

Limitations

Three new 1999 HCPCS codes are subject to limitations as described below.

- Injection administration codes 90471 and 90472 are limited to use with vaccine and toxoid codes 90476 through 90749. The existing limitation on other administration codes also applies to the new codes; that is, an office visit code and a vaccine or toxoid product code can be billed together, or the vaccine or toxoid product code and the administration code can be billed together, but all three codes cannot be billed for the same service on the same day. This limitation is added to the Medicaid Provider Manual for Physician Services, Section 2, Chapter 3, LIMITATIONS (page 17).

- Neonatal intensive care code 99298, subsequent neonatal intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (less than 1500 grams), is approved for NEONATOLOGISTS only. Prior authorization is not required.

Codes with Descriptor Changes

Codes on the Medical and Surgical Procedures Code List with descriptor changes have been corrected. Descriptor changes for codes covered by Medicaid include:

29848 Endoscopy, wrist, surgical, with release of transverse carpal ligament

Operating Microscope

As per the 1999 edition of CPT codes, use of code 69990, use of operating microscope, is as follows:

The surgical microscope is employed when the surgical services are performed using the techniques of microsurgery. Code 69990 should be reported (without the modifier -51 appended) in addition to the code for the primary procedure performed. Do not use 69990 for visualization with magnifying loupes or corrected vision. Do not report code 69990 in addition to procedures where use of the operating microscopes is an inclusive component (15756 - 15758, 19364, 19368, 20955 - 20962, 20969 - 20973, 26551 - 26554, 26556, 31526, 31531, 31536, 31541, 31561, 31571, 43116, 43496, 49906, 61548, 63075 - 63078, 64727, 65091 - 68850).

1999 Replacement Pages

Attached to this bulletin are five pages to update the Medical and Surgical Procedures Code List. A vertical line is placed in the margin next to text which has changed. An asterisk (*) indicates where text was deleted.

Remove outdated pages 23 - 24; 41 - 42; 43 - 44; 49 - 50; and 55 - 56. Replace these with the pages attached.

Corrections are effective January 1, 1999, in accordance with instructions for use of the 1999 HCPCS codes. For more information on effective dates, refer to Bulletin 99 - 25, *Health Common Procedure Coding System - 1999 Revisions.*

To economize on printing and mailing costs, pages on which the only change is a change in a code descriptor are not attached. If you want the updated list with code descriptor changes, please contact Medicaid Information. (See box at bottom of page.) Ask for the January 1999 Medical and Surgical Procedures Code List. □

98 - 35 Injectable Medications (J - Codes)

This bulletin describes coverage of injectable medication codes (J - codes) included in the 1999 Health Common Procedure Coding System (HCPCS) procedure codes update. Reimbursement to physicians for these J - Codes is made at 5% below Medicare's participating physician's allowable cost. HCPCS descriptors for covered codes, abbreviated in this bulletin, are given in full in the code list. J - codes which are not included on the Injectable Medications List are NOT covered by Medicaid.

For more information on the effective dates for 1999 HCPCS updates, refer to Bulletin 99 - 25, *Health Common Procedure Coding System - 1999 Revisions.*

Non-Covered J - Codes

The following 1999 HCPCS J- codes are NOT covered by Medicaid.

J0275 Alprostadil urethral suppository. . .
J1825 Injection, Interferon Beta-1A, 33 mcg. . .
J2792 Injection, RHO D Immune Globulin, Intravenous, Human, solvent detergent, 100 IU
J2994 Injection Reteplase, 37.6 mg (two single use vials)
J7190 Factor VIII (antihemophilic factor, Human) per IU
J7192 Factor VIII (antihemophilic factor, Recombinant) per IU

Covered J - Codes

The following codes are covered by Medicaid, effective January 1, 1999.

J0130 Injection, Abciximab, 10 mg
J0151 Injection, Adenosine, 90 mg (not to be used to report any Adenosine Phosphate compounds, instead use A9270
J0285 Injection, Amphotericin B, 50 mg
J0286 Injection, Amphotericin B, any lipid formulation, 50 mg
J0395 Injection, Arbutamine HCL, 1 mg
J0476 Injection, Baclofen, 50 mcg for intrathecal trial
J1260 Injection, Dolasetron Mesylate, 1 mg
J1956 Injection, Levofloxacin, 250 mg
J2271 Injection, Morphine Sulfate, 100mg
J2355 Injection, Oprelvekin, 5 mg
J7315 Sodium Hyaluronate, 20 mg, for intra articular injection
J7320 Hylan G-F 20, 16 mg, for intra articular injection
J7513 Daclizumab, parenteral, 25 mg
J9151 Daunorubicin Citrate, liposomal formulation, 10 mg
J9212 Injection, Interferon Alfacon-1, Recombinant, 1 mcg
J9310 Rituximab, 100 mg

Descriptor Changes

Descriptors for J - codes in this group were modified in the 1999 HCPCS update.

J0150 Adenosine, 6 mg (not to be used to report any Adenosine Phosphate compounds, instead use A9270
J1650 Enoxaparin Sodium, 10 mg
J1830 Injection Interferon Beta-1B, 0.25 mg, administered under direct physician supervision, excludes self administration
J3030 Sumatriptan Succinate, 6 mg, administered under direct physician supervision, excludes self administration

The Injectable Medications (J - Codes) List in the Utah Medicaid Provider Manual for Physician Services has been corrected to include the changes described above. Physicians, licensed nurse practitioners, osteopaths and podiatrists will find a copy of this list attached. Other providers who want the revised list should contact Medicaid Information; ask for the January 1999 Injectable Medications (J - Codes) List. □

99 - 36 Podiatric Services: Manual Updated

Section 2 for a new Medicaid Manual for Podiatric Services is effective April 1, 1999. Policy, code tables and Medicaid Information Bulletins issued previously to podiatrists are obsolete as of April 1.

Podiatrists will find attached Section 2, pages 1 - 13. To create a new Utah Medicaid Provider Manual for Podiatric Services, insert Section 2 after the last page of Section 1 and before the Table of Contents for General Attachments. A complete Medicaid manual contains three sections:

Section 1: General Information for all providers.

Section 2: Information specific to a provider type or program (policy, procedures, codes and billing).

General Attachments: attachments for all providers.

If you need a copy of either Section 1 or the General Attachments, please use the Publication Request Form attached or call Medicaid Information. □

99 - 37 Laboratory Services -- CLIA Requirements; 1999 HCPCS Codes

Place CLIA Number on Lab Claims!

We would like to remind all providers who bill for any type of laboratory services that the appropriate CLIA (Clinical Laboratory Improvement Amendments) number must be placed on the lab claim.

Please review this bulletin and distribute copies to staff who may have a need to know, particularly those billing Medicaid claims with laboratory procedure codes. As of January 1, 1999, Medicaid began denying clinical laboratory services billed by physician office laboratories which do not meet the CLIA requirements. Consequently, Medicaid is denying around 1,900 lab claims a week because of noncompliance with CLIA.

The next section of this bulletin is a reminder of CLIA requirements. The last section describes the 1999 HCPCS updates to the list of CLIA Certificates and Excluded Codes and the list of CLIA Waiver Kits. The CLIA lists are included with this bulletin.

CLIA Certification

The Clinical Laboratory Improvement Amendments of 1988 mandate that all laboratories must meet applicable Federal requirements and have a CLIA certificate in order to receive reimbursement from Federal programs, including managed care plans contracting with Medicaid.

1. CLIA also requires laboratories performing only certain tests to be eligible for a certificate of waiver or a certificate for Physician Performed Microscopy Procedures (PPMP). This policy is in the Utah Medicaid Provider Manuals for Physician Services and for Laboratory Services.

2. Claims will be denied to all labs when billed without a CLIA Certificate number, for services not covered by the CLIA Certificate, and for services rendered outside the effective dates of the CLIA Certificate.

For information on obtaining CLIA certification, contact your state laboratory licensing agency. The address and telephone numbers are in the box below.

Billing for Lab Services

The CLIA certification number must be included on each claim for laboratory services by any provider performing tests covered by CLIA, whether billed on a paper claim or in electronic format. This instruction for billing lab services, effective for claims with dates of service on or after July 1, 1998, was issued last July.

1. The HCFA-1500 instructions are part of your Medicaid Provider Manual. For your convenience, the CLIA instructions for Box 23 are repeated below.

   Box 23. Prior Authorization Number

   CLIA: For both Medicaid and UMAP clients, laboratory services with dates of services on or after July 1, 1998, must be billed on a separate claim form. Enter ONLY the ten digit CLIA certification number in this field. If you are billing multiple laboratories requiring different CLIA certification numbers, use separate claim forms for each CLIA certification number.

2. Laboratory services must be billed separately from all other services billed on a HCFA-1500 Form for both UMAP and Medicaid clients.

Lists of CLIA Certificates and Lab Codes

The list of CLIA Certificates and Excluded Codes and the list of CLIA Waiver Kits have been updated to include changes in the 1999 HCPCS update. Physicians, licensed nurse practitioners, osteopaths and labs will find a copy of both lists attached. Please remove the old two-page list and replace with the January 1999 list attached (pages 1 - 4).

Other providers who want the revised lists should contact Medicaid Information; ask for the January 1999 CLIA lists.

Notes on the CLIA Lists

1. The codes on the lists are identified by HCFA as requiring CLIA certification. However, all of the codes listed are not covered by Medicaid. Refer to Medicaid Provider Manuals for specific policy and limitations.
2. The codes in the column titled **Codes Excluded from CLIA Requirements** are still limited to billing for provider types previously identified by Medicaid.
3. Eight of the original codes (without the QW modifier) in the column titled **Certificate of Waiver** column are for tests, while the remaining codes are for specific kits approved by the Center for Disease Control. □

Obtaining CLIA Certification from the Bureau of Laboratory Improvement

For information on obtaining CLIA certification, contact your state laboratory licensing agency. In Utah, contact the Bureau of Laboratory Improvement. The telephone numbers are (801) 584-8471, 584-8472 or 584-8295.

The address is:
Bureau of Laboratory Improvement
46 North Medical Drive
Salt Lake City UT 84113

99 - 38 DRG Payment for Hospital Readmission Within 30 Days of Previous Discharge

Medicaid reimburses certain hospitals with a single diagnosis-related group (DRG) payment. The DRG payment covers all inpatient services to a Medicaid fee-for-service client, that is, a client not enrolled in an HMO. Effective April 1, 1999, when the client is readmitted to the hospital within 30 days of a previous discharge for the same or a similar diagnosis, Medicaid will evaluate the claims in question with the intent of combining the claims into a single claim.

After reviewing severity of illness, intensity of service, and financial benefit to the state, staff will determine whether reimbursement for the readmission will be included under the original diagnosis-related group payment (DRG) or paid separately. Interqual criteria will be used to determine whether the severity of illness or intensity of service criteria are met.

1. If Medicaid staff determine that either admission does not meet criteria for coverage, that admission will be denied, and the days associated with that admission will not be paid.

2. If Medicaid staff decide to combine the claims into a single DRG, the first DRG payment covers both admissions. Appropriate outlier days will be paid based on the actual days of inpatient services.

3. If claims are combined and a single DRG is paid, the payment may not exceed 110% of all billed charges for all stays.

4. For a pregnancy or chemotherapy related diagnosis, a second DRG payment may be made when the client is readmitted to the hospital within 30 days of a previous discharge. Severity of illness and intensity of service requirements still must be met.

Billing Patients Prohibited

Even though Medicaid may deny claims for readmission within 30 days of discharge, we want to remind providers that, generally, billing Medicaid patients is prohibited. See the box at the top of page 4 of this bulletin or refer to the Utah Medicaid Provider Manual, Section 1, *General Information*, Chapter 6 - 8, *Billing Patients*. Policy states, "A provider who accepts a patient as a Medicaid patient must accept the Medicaid payment as reimbursement in full . . .. A provider may NOT bill the patient for services covered by Medicaid."

For questions regarding this policy, please contact Medicaid Information.

Hospital Manual Updated

The information on evaluation of readmissions has been added to page 17 of Section 2 of the Utah Medicaid Provider Manual for Hospital Services, Chapter 3, LIMITATIONS, as a new item 18, Readmissions Within 30 Days of Previous Discharge. Because there are other pages corrected in Section 2, instructions for replacing the page are in Bulletin 99 - 39, *Hospital Manual Updated*. □

99 - 39 Hospital Manual Updated

Six updates to Section 2 of the Utah Medicaid Provider Manual for Hospital Services are described below. Corrected pages for Section 2 are attached. Instructions for filing the pages are at the end of this bulletin.

1. Medically Necessary Services

Bulletin 99-30, *Make Sure Medicaid Clients Receive All Medically Necessary Services*, updated one page, Chapter 1, *GENERAL POLICY*, page 2.

2. Rule References Corrected

Rules cited in three chapters are corrected as follows (corrections in bold print):

Page 5, Chapter 1 - 3, *Definitions*:

"In addition to the definitions in R414-1 ~~**and R414-31X**~~ of the Utah Administrative Code and Section 1 of this Medicaid Provider Manual, the following definitions apply."

Page 8, Chapter 2, COVERED SERVICES:

"All hospital inpatient and outpatient services are subject to review by the Department of Health for appropriateness according to **R414-1-12 and 14**, Utah

Administrative Code."

Page 16, item 8, *"Outpatient Hospital* services are limited. . .":

"Determinations of medical necessity and appropriateness are based on utilization management review and use of Inter-Qual medical review criteria as outlined in **R414-1-12**, Utah Administrative Code."

3. Coverage of Drugs

Information has been added on Medicaid criteria for coverage of drugs (Section 2, Chapter 2, COVERED SERVICES, item 19, page 8). Additional criteria and limitations are as follows:

a. Medicaid covers most medications prescribed by qualified practitioners as a Medicaid benefit, in compliance with Federal law (42 CFR 440.120). Coverage requirements are described in the Utah Medicaid Provider Manual for Pharmacy Services. A copy of the Pharmacy Manual may be obtained by contacting Medicaid Information.

b. Medicaid has additional requirements for drugs identified on the Drug Criteria and Limits List attached to this manual, including limits or requirements for prior authorization.

c. Nonprescription, over-the-counter items are limited to those OTC drugs on the Over the Counter Drug List attached to this manual.

Both lists are included with the Medicaid Provider Manual for Physician Services.

4. Coverage of Medical Supplies

Information has been added on Medicaid criteria for coverage of medical supplies (Section 2, Chapter 2, COVERED SERVICES, item 27, page 9). Additional information is as follows:

a. The Utah Medicaid Program covers medical supplies and equipment under four conditions: (1) The supplies and equipment are medically necessary; (2) they are ordered by a physician; (3) they meet the standards stated in policy and the Medical Supplies List, and they are within the limits specified; and (4) they are listed on the Medical Supplies List included with this manual. Coverage requirements are described in the Utah Medicaid Provider Manual for Medical Supplies. A copy of this manual may be obtained by contacting Medicaid Information. Medical necessity does not include use primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort. The physician's order must list each item required, a medical necessity, and be signed and dated by the physician or other licensed medical practitioner. An item simply marked on a preprinted multiple item order sheet is not acceptable.

b. The Child Health Evaluation and Care (CHEC) Program may approve medical supplies and medical equipment which are medically necessary for children less than 21 years of age. For specific information, please refer to the Utah Medicaid Provider Manual for Child Health Evaluation and Care (CHEC) Program Services. A copy of this manual may be obtained by contacting Medicaid Information.

5. Readmissions Within 30 Days of Previous Discharge

The information on evaluation of readmissions has been added to Chapter 3, LIMITATIONS, as a new item 18, Readmissions Within 30 Days of Previous Discharge (page 17). A reference to this new item has been added to Chapter 1, GENERAL POLICY, item A (page 3).

6. Telephone Number Corrected

On page 20 (Chapter 5, BILLING, item Electronic Billing with AcClaim Software), the Salt Lake area telephone number for Medicaid Information is incorrect. The correct number is **538-6155**.

Replacement Pages for Section 2

Attached to this bulletin are three replacement pages for the Utah Medicaid Provider Manual for Hospital Services. Each page has a revision date at the top right side of the page. A vertical line is placed in the margin next to text which has changed. Remove the existing pages in Section 2 and replace with the attached pages.

- pages 2 - 3 (Chapter 1), clarifying the requirement to ensure all medically necessary services by Medicaid providers.
- pages 8 - 9 (Chapter 2), correcting rule citation and adding information on Medicaid criteria for coverage of drugs and medical supplies.
- pages 16 - 17 (Chapter 3), correcting rule citation and adding the limitation on readmission within 30 days of previous discharge. □

99 - 40 Off-Label, Experimental and Investigational Drugs

Section 2 of the Medicaid Provider Manual for Pharmacy Services, Chapter 2 - 4, *Formulary*, is revised to expand policy on off-label, experimental and investigational drugs. Item B on page 12 is below. A vertical line in the margin indicates where policy has been added.

B. Off-Label, Experimental and Investigational Drugs

Utah Medicaid Program restricts the covered drug products on the open formulary to uses approved and documented by the officially recognized compendia [OBRA 1993, section 1927 (d) (6)]. The designated compendia are:

1. Package insert, FDA approved uses
2. American Hospital Formulary Service Drug Information (AHFS)
3. American Medical Association Drug Evaluation (AMADE)
3. United States Pharmacopeia Drug Information Drug Information (USP- DI)
4. DRUGDEX

Off-label Use

The Drug Utilization Review (DUR) Board may approve an unlisted off-labeled use for a given drug if the off labeled use meets ALL of the following criteria.

1. Use must be diagnosis specific as defined by an ICD-9 code (s).
2. Off-labeled use must be supported by one major multi-site study or three smaller studies published in JAMA, NEJM, Lancet or peer review specialty medical journals such as Journal of Cardiology. Articles must have been published within five years.
3. Off-labeled use must have a defined dosage regimen.
4. Off-labeled use must have a defined duration of treatment.
5. The off-labeled use shows clear and significant clinical or economic advantage over existing approved drug regimens.

Experimental Use

Experimental use is defined as drug use for indications not supported by FDA or published studies. Drugs prescribed for experimental use are **not** covered. As documentation accumulates for a given indication, the experimental drug use may move to the off-label category, as determined by the DUR Board.

Investigational Use

Investigational drugs or chemicals are not covered. Any drug or chemical that does not have an NDC number is deemed investigational.

The UMA, Utah-based Group Practices or Utah-based prescribers have the option of petitioning the DUR Board for coverage for an unlisted, off-labeled use of a given drug. The petitioner(s) must schedule an appearance before the Board to present the case for the petitioned drug. Petitioners must provide documentation including one published major multi-cite study or a minimum of three recent (five years) articles from JAMA, NEJM, Lancet or peer review specialty medical journals such as the Journal of Cardiology, supporting the petition's position. The documentation must be submitted six weeks in advance of the scheduled DUR Meeting.

Pharmacy Manual Updated

Included with this bulletin are pages 12 - 13 of Section 2 of the Utah Medicaid Provider Manual for Pharmacy Services. Remove the existing page 12 - 13 and replace with the updated page. ☐

99 - 41 Synagis® Coverage Extended to Resigam®

Bulletin 99 - 11, *Coverage and Recommended Guidelines for Synagis®*, issued January 1999 announced that Medicaid covers the new drug Synagis® (palivazumab) for prophylactic treatment of respiratory syncytial virus (RSV). The coverage guidelines for palivazumab are extended to include Respigam®, RSV immune globulin humane, effective January 1, 1999. This drug has been added to the Drug Criteria and Limits List which is included with the Medicaid manuals for physician services and for pharmacies.

- Note that these drugs are covered by the Medicaid Physician Services Program and not by the Pharmacy Services Program.

Please refer to the Drug Criteria and Limits List or Bulletin 99 - 11 for conditions for coverage for palivazumab and RSV immune globulin humane. As a reminder, ribavirin is the only approved treatment for RSV infection.

Dosage and Limitations

The recommended dosage for RSV immune globulin humane is 750mg/kg of body weight. It is available in a 20cc or a 50cc vial. Strength is 50mg/ml. Doses are limited to five per year administered once a month for five consecutive months, typically November through March, or the end of the RSV season, whichever comes first.

Billing for New Drugs

Until a unique J - code is assigned to Respigam® , RSV immune globulin humane, use code J3490 to bill. On page 1 of Medicaid's list of Injectable Medications, the instructions state that J3490 may be used for new drugs which have not been assigned a unique J - code.

If you submit the claim on paper, follow the instructions to identify the name of the drug, the strength and quantity on the claim form. If you bill the claim for J3490 electronically, a staff person will contact you to determine specifically the drug used. We will advise you as soon as a J - code is assigned.

Reimbursement

Medicaid will reimburse Respigam® at the direct manufacturer purchase price plus 10 percent (direct price + 10%). As of December 1998, the direct manufacturer purchase price for the 20cc vial is $267.39. The direct price + 10% is $294.13. The direct manufacturer purchase price for the 50cc vial is $531.53. The direct price + 10% is $584.68.

The provider may bill for services as directed in the Physician Services Provider Manual, Section 2, Chapter 2, COVERED SERVICES, item 23, which states, "An injection code which covers the cost of the syringe, needle and administration of the medication may be used with the J - Code when medication administration is the only reason for an office call. Note: An office visit, J - Code, and an administration code cannot be used all for the same date of service. Only two of the three codes can be used at any one time or at any one visit." □

99 - 42 Enbrel ® (etanercept) Covered with Prior Authorization

Effective January 8, 1999, Medicaid covers Enbrel ® (etanercept) with prior authorization. Etanercept is the first biologic response modifier approved for the treatment of patients with moderate to severe rheumatoid arthritis. Etanercept acts by binding tumor necrosis factor, one of the dominate cytokines in the inflammatory cascade.

Prior authorization is required. The patient's physician must obtain authorization from Medicaid. Criteria for coverage, as described in this bulletin, have been added to the Drug Criteria and Limits List attached. If the patient is enrolled in a managed care plan, etanercept is covered, but the provider must consult with the patient's plan for coverage criteria and reimbursement.

Conditions for Coverage

There are five conditions for coverage:

1. The patient must be at least four years of age.
2. The patient has severe rheumatoid arthritis. (ICD-9 714.0; 714.3)
3. The patient has documented history of treatment failure, incomplete response or intolerance to:
   A. Methotrexate
   B. At least one other DMARD or second line drug (azathioprine, gold, sulphasalazine, leflunomide, penicillamine, hydroxychloroquine, etc.) and
   C. NSAIDs
4. The patient has at least six or more swollen joints.
5. The patient has at least nine or more tender joints.
6. Patient does not have an immunosupressive condition.
7. Patient does not have an active bacterial or viral infection
8. Patient does not have a malignancy.
9. Patient has had a documented rheumatologist consultation within the last sixty days.
10. Etanercept may not be given with other biologic agents (such as interferon, etc.) or experimental medication combinations.

The request for prior authorization and documentation may be FAXed or mailed to the Medicaid Prior Authorization unit. Medicaid may approve the initial request for 12 weeks

or a maximum of 24 kits. Medicaid may approve a subsequent request for prior authorization if the patient has at least 20% improvement in four of the following six parameters: tender joint count, swollen joint count; patient global assessment of disease activity; physician global assessment; pain; acute phase reactants. The subsequent authorization may be for 12 months or a maximum of 112 kits.

Dosage

Etanercept is given SQ, twice weekly. Maximum dose is 25mg.

Preparation

- Etanercept is supplied as kit with 1 25mg lypholized vial and 1 vial diluent.
- Gently swirl vial after diluent is added. (Foams if shaken vigorously.)
- Dissolution takes less than five minutes generally.
- Reconstituted solution stable for six hours under refrigeration.

Reimbursement

Cost at EAC (AWP-12%). As of January 27, 1999, pricing is $121.00 or ~$ 1,129.33 per month. □

99 - 43 Coverage of RotaShield ® (rotavirus vaccine, live, oral, tetravalent)

Effective December 23, 1998, Medicaid covers RotaShield® (rotavirus vaccine, live, oral, tetravalent) when administered by a physician, osteopath or licensed nurse practitioner to a child 1 year of age or younger. Maximum doses covered: three.

Use the following CPT codes for the vaccine and administration:

90680 Rotavirus vaccine, tetravalent, live, for oral use

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and Jet injections and/or intranasal or oral administration); single or combination vaccine/toxoid.

Reimbursement

Reimbursement is AWP. As of January 1999, pricing is $48.25.

Drug Criteria List Revised

RotaShield® (rotavirus vaccine, live, oral, tetravalent) has been added to the Drug Criteria and Limits List. □

99 - 44 Drug Criteria & Limits List Revised

Three drugs have been added to the Drug Criteria and Limits List: Resigam®, Enbrel ® (etanercept), and RotaShield ® (rotavirus vaccine, live, oral, tetravalent). Coverage criteria are explained in the three preceding bulletins and on the list.

The list includes all drugs limited to a cumulative quantity in any 30-day period. Limits were approved by the Drug Utilization Review (DUR) Board. Drugs on the list do not qualify for 'early refills'. Physicians and other prescribers who feel that a patient has specific needs which exceed the limits may appeal to the DUR Board. All medications remain subject to all other requirements of Pharmacy Program, as described in the Utah Medicaid Provider Manual for Pharmacy Services.

References: Utah Medicaid Provider Manual for Pharmacy Services, Section 2, Chapter 4 - 7, *Early Refills*, and Chapter 4 - 9, *Limits on Certain Drugs*.

Note on Schedule II & III analgesics

Schedule II & III analgesics were added to the list in January 1999. These include Propoxyphene/APAP - hydrocodone/APAP; Codeine/APAP; and Oxycodone/APAP. Please note that liver toxicity occurs at APAP levels of 4 gms per day if taken on a routine basis.

Updating the Drug Criteria & Limits List

Physicians, osteopaths, licensed nurse practitioners and pharmacists will find attached pages 1 - 2, 13 - 14 and 15 - 16 to update the Drug Criteria and Limits List in their Utah Medicaid Provider Manuals. Please replace existing pages 1 - 2 and 13 -14 with the corrected pages attached and then add new page 15 - 16. □

99 - 45 Medical Supplies List Updated

This bulletin describes coverage of medical supply codes included in the 1999 Health Common Procedure Coding System (HCPCS) procedure codes update. Some codes require prior authorization or have other limitations. HCPCS descriptors for covered codes, abbreviated in this bulletin, are given in full in the code list. Medical supply codes which are not on the Medical Supplies List are NOT covered by Medicaid.

For more information on the effective dates for 1999 HCPCS updates, refer to Bulletin 99 - 25, *Health Common Procedure Coding System - 1999 Revisions.*

Non-Covered Codes

The following 1999 HCPCS medical supply codes are NOT covered by Medicaid.

A4261 Cervical cap for contraceptive use
A4483 Moisture exchanger, disposable. . .
A5200 Percutaneous catheter/tube anchoring device. . .
A9507 Supply of radiopharmaceutical diagnostic imaging agent. . .
A9605 Supply of therapeutic radiopharmaceutical. . .
E0785 Implantable intraspinal (epidural/intrathecal) catheter. . .
K0456 Hospital bed . . .
K0457 Extra wide/heavy duty commode chair. . .
K0458 Heavy duty walker. . .
K0459 Heavy duty wheeled walker. . .
L1690 Combination, bilateral, lumbo-sacral, hip, femur orthosis. . .
L1847 Knee orthosis, double upright with adjust. joint. .
L5975 All lower extremity prosthesis, combination. . .
L5988 All lower extremity prosthesis, combination. . .
L6693 Upper extremity addition, external lock. elbow. .
L8015 External breast prosthesis garment. . .
L8035 Custom breast prosthesis. . .
L8195 Gradient compression stocking, waist length. . .

Discontinued Codes

CodeY0455, Spirometer/peak flowmeter, is discontinued April 1, 1999. It is replaced by A4614 which may be used for dates of service on or after January 1, 1999.

Medical Supply Codes

Medicaid covers the 1999 HCPCS codes listed in this section. A abbreviated descriptor is given. Codes are grouped by category in the Medical Supplies List, followed by the page number on which the change occurs. Criteria for codes which require prior authorization are on the Medical Supplies List attached. For your convenience, they are described *briefly* in this bulletin as well.

MISCELLANEOUS SUPPLIES, page 8:
The following code is covered, but not for a resident of a nursing home. Limit is one per year.
A4614 Peak expiratory flow rate meter, hand held.
This code replaces code Y0455, spirometer/peak flowmeter, which will be discontinued April 1, 1999.

DECUBITUS CARE, page 21:
The following codes are covered, including for a resident of a nursing home. All have a limit of one daily.
A6200 Composite dressing, pad size 16 sq. in. or less...
A6201 . . . pad size more than 16 sq. in. but less than or equal to 48 sq. in....
A6202 . . .pad size more than 48 sq. in...

ADDITIONAL OXYGEN RELATED EQUIPMENT, page 31:
Code A4614, Peak expiratory flow rate meter, hand held, replaces code Y0455. See "MISCELLANEOUS SUPPLIES" above for more explanation.

WHEELCHAIR and WHEELCHAIR ACCESSORIES, pages 39 - 40:
The following two codes require written prior authorization. They are not covered for a resident of a nursing home. The limit is one per lifetime. Payment is by invoice.
K0460 Power add-on, to convert manual wheelchair to motorized wheelchair, joystick control
K0461 . . . . tiller control

Criteria for these codes are:
1. Physician order
2. Physical therapist reviews with written advice
3. Disability described:
   a. Required for home use (not outdoor travel).
   b. Manual wheelchair is five years old or less.
   c. Physician and physical therapist document that manual wheelchair is no longer adequate.
   d. Projected use is for at least five years without requiring a new motorized chair.

UPPER LIMB, page 51:

A limit of one per year is placed on codes L3650 and L3670.

New code added, L3675 SO, vest type abduction restrainer, canvas webbing type or equal. Requires written prior authorization. New code is covered for a resident of a nursing home. Limit is one per year. Criteria are:

1. Physician ordered
2. Diagnosis or description of disability
3. No other ankle has been provided within a year
4. Medical necessity for shock absorbing ankle identified

PROSTHETICS, LOWER LIMB, page 56:

L5968, All lower extremity prostheses, ankle, multiaxial shock absorbing system. Code requires prior authorization. It is covered for a resident of a nursing home. Limit is 1 every 5 years. Criteria are

1. Diagnosis or description of disability
2. No other ankle has been provided within a year
3. Medical necessity for shock absorbing ankle identified

Descriptor Changes

Descriptors for codes in this group were modified in the 1999 HCPCS update. (Descriptor abbreviated.)

L5840 Addition, endoskeletal knee/shin system. . .. .
L8420 Prosthetic sock, multiple ply, below knee, each
L8430 Prosthetic sock, multiple ply, above knee, each
L8470 Prosthetic sock, single ply, fitting, below knee, each
L8480 Prosthetic sock, single ply, fitting, above knee, each
L8485 Prosthetic sock, single ply, fitting, upper limb, each

Corrected Pages for Medical Supplies List

Physicians and medical suppliers will find attached six pages to update the Medical Supplies List. Pages are 7 - 8, 21 - 22, 31 - 32, 39 - 40, 51 - 52, and 55 - 56. Changes on a page are marked by a vertical line in the left margin. In addition, new codes are in bold print.

To economize on printing and mailing costs, a page on which the only change is a change in a code descriptor is not included with this bulletin. Also, the five page alphabetical and numerical indexes are not attached. If you have any questions or want an updated Medical Supplies List which includes code descriptor changes and the updated index, please contact Medicaid Information. Ask for the January 1999 Medical Supplies List. □

99-46 Medicaid Bulletins Now in Acrobat Reader

The software product Adobe Acrobat Reader® allows the Medicaid Information Bulletin to appear on the Internet exactly as the original, printed document. Text, columns, graphics, fonts and formatting are preserved. You can print copies which look just like the original bulletin using any computer, any browser, and any printer. Acrobat Reader is a FREE product.

If Acrobat Reader is installed on your personal computer, you just 'click' on the link to the bulletin to view it.

Installing Adobe Acrobat Reader

If Acrobat Reader is not yet installed, and you have a new version of an Internet browser (for example, Netscape 4. or newer), usually Acrobat Reader will self-install on your computer when you click' on the link to the bulletin. After a short delay for the one-time only installation, the bulletin will open in its own window.

If your Internet browser is an older version, you may have to assist the software installation. 'Click' on the link to Adobe Acrobat Reader and follow instructions. With some browsers, you may have one more step. If presented with a menu choice before the bulletin opens, choose 'pick app'. Select the file 'acrord 32.exe', typically located in the folder Netscape - Acrobat 3 - reader - program. Select the 'acrord 32.exe' file to complete installation of Acrobat Reader. The bulletin should open for your viewing pleasure.

If you continue to have problems, Adobe offers customer support. Check out their trouble shooting suggestions on the Internet from the link:

http://www.adobe.com/supportservice/custsupport

Provider Manuals to Be Published in Adobe Acrobat

Eventually, all Utah Medicaid Provider Manuals will be published on the Internet in Adobe Acrobat. Should the user want to print the manual, it will appear exactly as intended. If there are questions about the use of Adobe Acrobat or comments about the format of bulletins and provider manuals, please contact the editor Donna Kramer.
E-mail: dkramer@doh.state.ut.us
Office Telephone: 801-538-7077
Toll-free: 1-800-662-9651 (Medicaid Information: ask to be transferred to Donna Kramer) □

99 - 47 Vision Care Services Manual Updated

Section 2 of the Medicaid Manual for vision care providers has been updated to provide expanded information on services covered. Policy, code tables and Medicaid Information Bulletins issued previously to vision care providers are now obsolete. Policy regarding stolen eyeglasses has been removed.

We would like to point out two code changes and remind you of the policy concerning replacement of eyeglasses.

Prostheses Services

Two code changes for prostheses services which occurred in April 1, 1997, are included in the update. Those changes were:

- Code Y0362, eye, artificial, polishing, was discontinued.
- The replacement code was V2624, polishing/ resurfacing of ocular prosthesis.

Replacement of Eyeglasses

Medicaid reimburses only one pair of eye glasses in a two-year time period. Glasses cannot be replaced more frequently than once every two years unless the replacement is needed for one of the reasons listed below. The provider must document in the patient record the reason for replacing lenses. The provider does not need to obtain prior authorization to replace lenses. Eyeglasses may be replaced ONLY under the following circumstances.

A. Vision change

Medicaid reimburses for a new prescription only (1) for a diopter change of .75 or (2) when disease or damage to the eye makes a change medically necessary. When the lenses are replaced, the new lenses must be placed in the client's previous frames. New frames will not be provided unless medically necessary.

B. Lost or Broken Eyeglasses

1. Client engaged in a formal educational process.

Medicaid allows one replacement of lenses and frames each twelve months when the original glasses are lost or broken beyond repair and the client is engaged in a formal educational process, such as preschool, elementary, junior high, high school, college or trade school. However, replacement of lenses and frames due to blatant abuse and neglect by the client is not covered.

2. Automobile accident

When the original glasses are lost or broken due to an automobile accident, the provider must bill the insurance company before billing Medicaid. Medicaid will reimburse for replacement lenses only if the insurance company pays less than the Medicaid reimbursement amount.

Updating the Vision Care Manual

Vision care providers will find attached replacement pages for the Utah Medicaid Provider Manual for Vision Care Services. (Ophthalmologists, please call Medicaid Information to obtain a copy of Section 2 of the Vision Care Services Manual. We were not able to include ophthalmologists in the mailing group for the Vision Manual.)

To update the vision care manual, remove Section II, Scope of Services, pages 2-1 through 2-10, and Section 7, Procedure Codes for Vision Services, pages 7-1 through 7-7. Replace the pages removed with the updated Section 2 attached, pages 1 through 17. Section 2 goes after the last page of Section 1 and before the Table of Contents for General Attachments.

A complete Medicaid manual contains three sections:

- Section 1: General Information for all providers.

- Section 2: Information specific to a provider type or program (policy, procedures, codes and billing).

- General Attachments: attachments for all providers.

If you need a copy of either Section 1 or the General Attachments, please use the Publication Request Form attached or call Medicaid Information. □

99 - 48 Nursing Facility Refunds to Medicaid Clients Who Paid the Private Pay Rate

When a nursing facility resident is or becomes eligible for Medicaid, the resident's financial liability is limited to the monthly client contribution to cost of care required by Medicaid. The client contribution, also called the Family Income amount, is determined by the Medicaid eligibility worker. The Family Income amount is stated in the Medicaid notice of eligibility and on the Turn Around Document (TAD).

If the resident has paid or been billed at the private pay rate for the month and then becomes eligible for Medicaid for the same month, the facility may owe the client a refund. The facility must refund to the client the difference between the amount paid and the Family Income amount. The facility may bill Medicaid for any cost of care not covered by the Family Income amount.

The facility must refund any excess income paid because it is required to accept the Medicaid reimbursement amount as payment in full. The Medicaid reimbursement is the client's contribution to cost of care *plus* the remainder of the Medicaid per diem payment.

If you have questions about this policy, please contact the Medicaid eligibility worker for your facility or the Nursing Home/Waiver Coordinator, Rich Nelson. Contact Rich Nelson at:

Mailing address: Division of Health Care Financing
P.O. Box 143107
Salt Lake City UT 84116-0580

FAX: 1-801-538-6952

Telephone: 1-801-538-6494

To call toll-free, call Medicaid Information and ask to be transferred to Rich Nelson at extension 8-6494.

We appreciate your help to make sure that residents eligible for Medicaid are not billed in excess of the required contribution to cost of care. □

99 - 49 Long Term Care in Nursing Facilities: Manual Issued

Long term care providers will find attached Section 2 of the Utah Medicaid Provider Manual and appendices. Policy and Medicaid Information Bulletins issued previously to long term care providers are now obsolete.

Section 2 includes information on covered services, client rights, and the rights and responsibilities of nursing facilities. Specific policy includes:

- Appropriate Placement
- Provider enrollment
- Requirements for nursing
- Preadmission screening and continued stay review
- Program certification and resident assessment
- Billing and reimbursement
- Payment rates and cost profiling

The appendices include the following:

- Provider Contract and Agreement
- Nurse Aide Training and Competency Evaluation Program
- Long Term Care Turnaround Document (TAD) and Instructions
- Medicaid Publications
- Preadmission/Continued Stay Inpatient Care Transmittal (Form 10A) and Instructions
- Minimum Data Set (MDS) Form
- Utah State Plan, Nursing Facility Reimbursement for Services, and addendums (facility cost profile instructions)

New Provider Contract

The Medicaid agency will implement the new provider contract with individual providers at the time of their annual certification survey over the span of the upcoming fiscal year (July 1, 1999 - June 30, 2000).

Updating the Long Term Care Manual

To create a new Utah Medicaid Provider Manual for Long Term Care Services, insert Section 2 after the last page of Section 1 and before the Table of Contents for General Attachments. A complete Medicaid manual contains three sections:

- **Section 1:** General Information for all providers.

- **Section 2:** Information specific to a provider type or program (policy, procedures, codes and billing).

- **General Attachments:** attachments for all providers.

Providers who did not receive the new manual and would like a copy of Section 2 of the Long Term Care Services Manual, or who need a copy of Section 1 or the General Attachments, should use the Publication Request Form attached or call Medicaid Information. □

Requesting a Medicaid publication or form?
- Send the Publication Request Form attached.
- by FAX: **1 - 801 - 538 - 6805**
- by mail

Mailing address: Division Of Health Care Financing
Box 142911, Salt Lake City UT 84114-2911

Medicaid Information:
- Salt Lake City area, call **538-6155.**
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free **1-800-662-9651.**
- From other states, call **1-801-538-6155.**
- Department Of Health, Division Of Health Care Financing
INTERNET SITE: **http://www.health.state.ut.us/medicaid**

99 - 50 Y2K Talking Points for HCFA Activities

The following discussion is adapted from a Y2K briefing issued by the federal Health Care Financing Administration (HCFA). The original briefing, Year 2000 Provider Outreach Activities, is on the Internet at http://www.hcfa.gov/y2k. The Utah Medicaid agency supports HCFA's position regarding Y2K compliance.

WHAT IS THE YEAR 2000 (ALSO KNOWN AS THE Y2K) CHALLENGE AND WHY IS IT IMPORTANT?

Many computers use just two digits to record the year. If no action is taken, these computers will recognize "00" as 1900 rather than 2000, resulting in many potential problems for computer systems and health care providers.

The computer systems of HCFA and its partners are critical to processing claims for millions of Medicare and Medicaid beneficiaries. Dates are important to most systems. For example, critical dates are the date a beneficiary becomes eligible for Medicare/Medicaid, the date a patient is admitted to or discharged from a hospital, the date a wheelchair rental begins, or the date an enrollee enters a managed care plan. Date-related transactions such as these occur millions of times a day. If the Y2K date problem is not resolved, providers may experience delayed payments or disruptions in receiving data upon which they rely.

WHAT IS HCFA'S PLAN TO BE Y2K READY?

HCFA's number one priority is complying with the Year 2000 challenge. The goal is to ensure that beneficiaries get health care, and providers continue to receive prompt and efficient payment for their services into the Year 2000.

HCFA and companies that process and pay claims must identify problems and renovate all computer and information systems. Renovated systems must be tested multiple times to make sure the new corrections work. Year 2000 activities take precedence over other projects that require changes to computer and information systems.

HCFA COMMITS RESOURCES TO Y2K COMPLIANCE

Following are some actions HCFA has taken:

- setting up special teams of employees whose sole responsibility is making Year 2000 fixes;
- hiring retired federal programmers to help with Year 2000 efforts;
- hiring contractors to fix Y2K problems and test systems to make sure they work properly;
- closely tracking contractor progress to ensure work is on schedule;
- amending agreements with fiscal intermediaries and carriers to ensure that they use information technology that is Year 2000 compliant;
- creating a contingency planning unit so disruptions do not result from any unexpected problems; and
- working within the Administration and with Congress to increase funding for Y2K renovation efforts.

HCFA and its contractors, who process and pay nearly one billion Medicare claims each year, have a strict schedule to fix and test their systems. Systems must be Y2K ready by December 31, 1998. This allows another twelve months to continue testing. State Medicaid Agencies are expected to be Y2K ready no later than March 31, 1999.

ENSURING WORK WILL BE COMPLETED ON TIME

HCFA has teams to monitor weekly progress and also sent representatives to 17 critical contractor sites to monitor daily progress. HCFA hired two independent verification and validation firms. One assessed the ability of HCFA and its contractors to be Y2K compliant. The other will confirm that all key systems will properly function in the year 2000. These experts recommended that HCFA and its contractors concentrate efforts and resources exclusively on Year 2000 compliance.

SOME SYSTEM CHANGES POSTPONED

The independent verification and validation firms recommended that HCFA and its contractors concentrate efforts and resources exclusively on achieving Year 2000 compliance. For example, contractors may postpone changes in their systems required to carry out some provisions of the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997. Reluctantly, HCFA may suspend some provisions until Year 2000 compliance can be assured.

WILL HCFA SYSTEMS FUNCTION IN THE YEAR 2000?

HCFA will do everything it must to ensure that its mission-critical systems function in the Year 2000 and its partners meet the Y2K challenge. Hospitals and physicians will continue to be paid, and critical information will continue to be available. HCFA will also assist medical providers in making their diagnostic equipments and office systems Y2K compliant. □

99 - 51 Federal Y2K Biomedical Equipment Clearinghouse

The U.S. Food and Drug Administration established a World Wide Web database with information on the Year 2000 compliance of medical devices, scientific laboratory equipment and biomedical equipment. To be Year 2000 (Y2K) compliant, products must function as intended regardless of the date. The product must accurately calculate, compare, display, record and sequence dates and times, including correctly processing leap year data.

The database, called the Federal Y2K Biomedical Equipment Clearinghouse, can be accessed at http://www.fda.gov/cdrh/yr2000/y2kintro.html. The site has comprehensive and up-to-date information on products which may have Y2K problems. It is an excellent starting point to assess biomedical equipment. Information is listed by manufacturer, product and model number. Manufacturers certify that their products do not have date-related problems or give information on products with a problem and solutions to mitigate the problems.

Please direct questions on the status of specific products to the manufacturer. The Food and Drug Administration does not have information on specific products. In addition, the FDA has not tested or evaluated the Year 2000 compliance status of products listed or not listed in the product database. For more information, please go to the web site http://www.fda.gov/cdrh/yr2000/y2kintro.html. □

99 - 52 FDA Medical Device Malfunction Advisory

The FDA warns health care practitioners that computer date malfunctions may already affect some medical devices. There are at least two devices which will not work correctly after December 31, 1998 and others which will have problems January 1, 2000.

Products with Problems

The most likely errors with products which calculate dates are that time and date of operation may not display, print or store correctly. While a printed test result that is incorrectly dated may not be an immediate risk to patient care, it is confusing and results in incorrect records.

There are two products with verified problems. The Hewlett-Packard 43100A/43200A external defibrillator defibrillates properly but prints "set clock" rather than the month, day, hour, and minute. Thirty-nine thousand defibrillators were sold worldwide between 1985 and 1992. The second product, Invivo Research Inc.'s Millennia 3500 multiparameter patient monitor, has a potential New Year's Eve problem every year. If the display clock is tested or reset as the year turns over, the display and internal clocks become asynchronous. The display clock and paper record show different times and dates until the product is powered down and restarted. This system has been sold since June 1996, and more than 2,000 are installed worldwide.

There may be other devices with similar, unidentified problems. Health care providers should be alert to the date display, printing of dates, device records and date recording of medical devices, especially on or after January 1. Date-related problems may manifest in unexpected ways.

Some date-related errors may put patients at risk. An example is a product for planning the delivery of radiation treatment using a radioactive isotope as the radiation source. An error calculating the radiation source strength on the day the therapy is delivered could result in incorrect treatment and adverse consequences for the patient.

Getting More Information

Preliminary concerns do not mean a problem has been confirmed. If a message about a product is questionable, or there are concerns, contact the manufacturer for specific technical information. The FDA may also be able to assist you in contacting the manufacturer.

FDA (HFE-88)
5600 Fishers Lane
Rockville, MD 20857

1-888-INFO-FDA (1-888-463-6332)

See also Bulletin 99-51, Federal Y2K Biomedical Equipment Clearinghouse Federal, for more information on the federal database on biomedical equipment.

Reporting Concerns

Any facility or device user who becomes aware of an unexpected, date-related problem associated with the transition from December 31, 1998 to January 1, 1999 is requested to notify the manufacturer and to report the problem as a malfunction to MedWatch, the voluntary program for reporting problems to FDA. The MedWatch telephone number is 1-800-332-1088; or use FAX number 1-800-332-0178. □

99 - 53 Director's Memo to Medicaid Providers

Dear Health Care Partner:

As a health care practitioner, you need to be aware of how the Year 2000 (Y2K) computer problem may affect you and your patients. We all must do our part so that Medicaid clients continue to receive high quality care, and you continue to be paid accurately and promptly.

The Year 2000 problem occurs when computers and devices use only six digits to record dates. They may read 01-01-00 as January 1, 1900, rather than January 1, 2000. Patient care services, systems, and devices that rely on dates, the age of the patient, and other calculations could be severely affected if corrections are not made in time.

Every business and organization that relies on computer systems or devices must address Y2K. For all of us in the health care industry, it is a patient care issue as well as a business and technical problem. As Director of the Division of Health Care Financing Administration (DHCF), I want you to be aware of some key points:

- We are reviewing, testing and correcting our systems so that we continue to process acceptable claims into the Year 2000.
- We are confident that Medicaid claims processes will be ready, and you will continue to be paid promptly. However, we are making contingency plans. Then we can continue operations if unexpected problems occur.
- Your systems must also be ready if you wish to be paid promptly. We can process your claims only if your systems also function in the Year 2000. It is URGENT that you act NOW so your systems will be ready. Otherwise, you may not be able to receive prompt payment from Medicaid, Medicare, or any other payer.
- Your entire practice and facility must be ready. The Y2K problem could impact quality of care and patient safety. Patient management systems, clinical information systems, defibrillators and infusion pumps and other medical devices, even elevators and security systems all must be ready.

We all must do our part so that Medicaid beneficiaries continue to receive high quality care, and you continue to be paid accurately and promptly. Here are key steps you can take to become Y2K ready:

- Find out how the Year 2000 can affect your systems. Anything that depends on a microchip or date entry could be affected. Identify organizations that you depend on or who depend on you. Identify your mission-critical items, namely, those you cannot live without.
- Assess the readiness of everything on your list. Contact your hardware or software vendors or access key information from various web sites. Don't forget your maintenance and service contractors. If your particular software program or form is not Y2K ready, you need to decide whether you should invest in an upgrade or replacement.
- Update or replace systems, software programs, and devices you decide are critical for your business continuity.
- Test your existing and newly purchased systems and software. Do not assume that a system or a program is Y2K ready just because someone said it is. Test to make sure. During this process, keep track of your test plans and outputs in case a problem surfaces later. If you are not already using compliant electronic claim formats, consider testing your electronic data interchanges (EDI) with one or more of your payers, including Medicaid. This will ensure that third party payers can accept your EDI transactions, especially claims.
- Develop business contingency plans for critical operations. These should focus especially on assuring safety for patients who rely on equipment and devices containing embedded chips. You also need to assure your ability to generate bills, manage accounts receivables, and maintain essential services and supplies. Your patients and your business may depend on this.

We will use Medicaid Information Bulletins to alert you to known Y2K problems with medical devices when information is posted on the Food and Drug Administration's web site:

www.fda.gov/cdrh/yr2000/year2000 .

Enclosed is a sample Provider Y2K Readiness Checklist which you may find helpful. It is only meant to be a guide and should not be considered all-inclusive. You can obtain more information from the federal Health Care Financing Administration (HCFA). The address and telephone numbers are in the box below.

Sincerely,

Michael Deily
Director
Division of Health Care Financing

Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244
Phone 410/786-3000

Salt Lake area telephone: 801-538-3910
Utah toll-free: 1-800-439-3805

web site: www.hcfa.gov/Y2K

HCFA TTY For the Hearing and Speech Impaired:
1-800-820-1202

SAMPLE PROVIDER Y2K READINESS CHECKLIST

This checklist may help you determine your Y2K readiness. It is intended only as a supplemental guide. The checklist is not intended to be all inclusive. Consider using this with other diagnostic and reference tools you have obtained for the Y2K project.

Item	Y2K Ready	Not Y2K Ready	Contingency Plan
Bank debit/credit card expiration dates			
Banking interface			
Building access cards			
Claim forms and other forms			
Clocks			
Communication Systems			
Computer hardware (list)			
Computer software (list)			
Custom applications (list)			
Diagnostic equipment (list)			
Disaster Management Plan			
Elevators			
Financial and accounting systems			
Fire alarm system			
Insurance/pharmacy coverage dates			
Membership cards			
Medical Devices (list)			
Monitoring equipment (list)			
Power Source			
Safety vaults			
Security systems			
Smoke alarm			
Spreadsheets			
Telephone system			
Transportation systems			
Treatment equipment (list)			
Water and wastewater systems			

Requesting a Medicaid publication or form?
- Send the Publication Request Form attached.
- by FAX: **1 - 801 - 538 - 6805**
- by mail

Mailing address: Division Of Health Care Financing
Box 142911, Salt Lake City UT 84114-2911

Medicaid Information:
- Salt Lake City area, call **538-6155.**
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free **1-800-662-9651**.
- From other states, call **1-801-538-6155**.
- Department Of Health, Division Of Health Care Financing
INTERNET SITE: **http://www.health.state.ut.us/medicaid**